IC

[If you need additional space for ANY section, please attach an additional sheet and reference that section.]

JoAnn Maldonado)
Plaintiff)
v.)
SSA Administration)
Defendant)

United States District Court
Northern District of Illinois

24cv9423
Judge Matthew F. Kennelly
Magistrate Judge Heather K. McShain
CAT 1
RANDOM

COMPLAINT

Hippa law broken - Dr Norris, Jeffrey SD, CA. "Do not give patent her medical records"

Interference in Righteous Justice in several cases + cure of Norwegian Crusted Scabies after numerous hospital stays & medical provider visits.

Denying I am a fainter from a childhood age disabled with AFIB, anemia + weakened immune system in IL.

Onset of bodily federal injuries by Tom Ferris negligent driving in 1999. 2013 case. Rejith refusal to pay disability money both while singe then married to Jorge Luis Maldonado in IL prior to Jorge's reckless homicide on July 27, 1989.

Funds not provided as they should have been 3/2022 with $0 + unequalized through the end of the year while being told I needed to go to work because by your standards, I was not qualified falsifying my disabled conditions & spreading highly contagious Norwegian Crusted Scabies -

[If you need additional space for ANY section, please attach an additional sheet and reference that section.]

You broke the USDA laws!

MALDONADO, JOANN T (id #48263, dob: 01/24/1966)

Assessment / Plan

1. Chronic back pain - Chronic back pain without red flags. Trigger point injections helped.
-Trigger point injections done tonight
-Will order wheelchair and pain management referral when patient changes insurance from Health Net to insurance we work with
-Lumbar xray per pt request as "something has changed", though I doubt will show any differences compared to prior with DDD in 12/2016
M54.9: Dorsalgia, unspecified
- XR, LUMBOSACRAL SPINE, 2 OR 3 VIEW - Note to Imaging Facility: acute on chronic low back pain

2. Delusional disorder--
Pt with chronic fixed delusion about loss of a pregnancy. Have found no evidence that patient was pregnant, though likely an episode of IPV or pregnancy loss has caused fixed delusion.
-DO NOT CHALLENGE PATIENT on delusions
-Establish rapport
-Do not release records to patient (chart flagged)
F22: Delusional disorders

3. Hypothyroidism - Reports possible hypothyroidism symptoms. Last labs in 2016 showed possible subclinical hypothyroidism.
-Repat TSH with reflex T4
E03.9: Hypothyroidism, unspecified
- TSH W/REFLEX TO FT4

4. Fibromyalgia - With known fibromyalgia.
-Needs pain management when changes insurance from Health Net to insurance we work with
M79.7: Fibromyalgia
- amitriptyline 10 mg tablet - Take 1 tablet qHS for 3 days, then 2 tabs qHS for 3 days, and from then after, take 3 tabs qHS
Qty: 90 tablet(s) Refills: 3 Pharmacy: WAL-MART NEIGHBORHOOD MARKET 5638 Note to Pharmacy: For sleep and fibromyalgia

Return to Office

- Enrollment for ENROLLMENT 30 at Medical Clinic visit on 04/21/2017 at 09:30 AM
- Marc Stevenson, L.C.S.W. for BEHAVIORAL HEALTH EST at Mental Health Visit on 05/01/2017 at 09:00 AM
- LAB for LAB WORK 15 at Medical Clinic visit on 05/05/2017 at 09:20 AM
- Jeffrey Norris, MD for FOLLOW UP 20 at Medical Clinic visit on 05/25/2017 at 06:20 PM

Encounter Sign-Off

Encounter signed-off by Jeffrey Norris, MD, 04/20/2017.

Encounter performed and documented by Jeffrey Norris, MD
Encounter reviewed & signed by Jeffrey Norris, MD on 04/20/2017 at 8:38pm

Encounter Date: 04/04/2017

Patient

Name	MALDONADO, JOANN (51yo, F) ID# 48263	**Appt. Date/Time**	04/04/2017 03:00PM
DOB	01/24/1966	**Service Dept.**	Medical Clinic visit
Provider	KANWARDEEP KALEKA, MD		
Insurance	Med Primary: MEDI-CAL - INSTITUTIONAL (MEDICAID) Insurance # : 98713919E Med : MEDI-CAL - INSTITUTIONAL (MEDICAID) Insurance # : 98713919E Prescription: CMX - Member is eligible. details		

Chief Complaint

None recorded.

Patient's Pharmacies

WAL-MART NEIGHBORHOOD MARKET 5638 (ERX): 2121 IMPERIAL AVE, SHERMAN HEIGHTS CA 92102, Ph (619) 849-5834, Fax (619) 849-5835
ST. VINCENT DE PAUL HEALTH CENTER DISPENSARY: 1501 IMPERIAL AVENUE, SAN DIEGO CA 92101, Ph (619) 233-8500, Fax (619) 645-6470

Vitals

Wt:	168 lbs 04/04/2017 03:11 pm	**Ht:**	5 ft 7 in 04/04/2017 03:11 pm	**BMI:**	26.3 04/04/2017 03:11 pm
BP:	125/83 sitting L arm 04/04/2017 03:11 pm	**O2Sat:**	98% Room Air at Rest 04/04/2017 03:11 pm	**Pulse:**	76 bpm regular 04/04/2017 03:12 pm

MALDONADO, JOANN T (id #48263, dob: 01/24/1966)

GYN History not reviewed (last reviewed 03/14/2017)
Date of LMP: 01/26/2017.
Duration of Flow (days): 7.
LMP: Unknown.
Frequency of Cycle (Q days): 14.
Menses Monthly: Y.
Flow: Heavy.
Age at First Child: 15.
Age at Menarche: 12.
Current Birth Control Method: Condoms.
On BCP's at Conception?: N.

Obstetric History

Obstetric History not reviewed (last reviewed 12/15/2016)

Past Medical History

Past Medical History not reviewed (last reviewed 12/15/2016)

HPI

Back pain: "Scripps didn't do anything for me". Went to ED few days ago.

Had walker in past. Would like another one. Had bought her own. Had from Oct 2015 to Oct 2016. Richard, ex-partner, got high on spice, and walker was broken.

"Nerves in the R feet is shot from accident years ago". R leg colder than L for years. Was told at Alvarado "the tendon in my R leg is tearing more". "There has been tearing in my back, I went to Mercy twice". Came into SVDP three times, was not able to get walk in. Says fibro is really bothering her; skin too sensitive. Says O2 sat machine hurts finger, has to try to take clothing off. Would like to work on this.

No urinary or stool incontinence. No saddle anesthesia.

Tooth infection/crack: saw dentist two days ago. Seen here. Got amoxicillin. Now feeling better.

Thyroid concerns: feels like hair coming out like used to. Also weight going up and down. Feeling colder than did in past.

ROS

Additionally reports: Gen: tired
Psych: stressed

Physical Exam

Patient is a 51-year-old female.

Constitutional: General Appearance: healthy-appearing, well-nourished, and well-developed. Level of Distress: NAD.

Psychiatric: Mental Status: active and alert and**abnormal affect; reactive affect, mood anxious.**

Head: Head: normocephalic and atraumatic.

Eyes: Lids and Conjunctivae: non-injected and no discharge.

Neck: Neck: trachea midline and no masses.

Lungs: Respiratory effort: no dyspnea; **speaking in full sentences.**

Musculoskeletal:: Joints, Bones, and Muscles: **ttp of the paraspinal muscles in the lower back and ttp of the bilateral medial trap ridges with diffuse muscle tension.**

Neurologic: Gait and Station: normal gait and station.

Procedure Documentation

Trigger Point Injections:

After discussion of the risks, benefits, and alternatives, the patient elected to proceed with trigger point injections. Informed consent was obtained and form signed. Confirmed that the patient does not have history of prior adverse reactions, active infections, or relevant allergies.
Most painful sites in relevant muscle then identified via palpation. After cleaning skin with alcohol wipe, 0.5 cc of 1% lidocaine without epi then injected into most pain muscular sites, including 5 sites in the R lower paraspinal muscles, 3 in L lower paraspinal muscles, and 1 each in each trapezial ridge. < 1 cc bleeding noted. No complications. Patient had no questions.

United States Treasury 15-51 000 B 418,493,009

Check No.

07 01 22 28040004 KANSAS CITY, MO 4032 48607005
000779904729 4032 48607005 W 00000220618MDM

Pay to the order of
JOANN T MALDONADO
2715 W HARRISON ST
CHICAGO IL 60612 3422

$*****246*90

VOID AFTER ONE YEAR

REGIONAL DISBURSING OFFICER 008

Vora L. Robinson

026621

SSI FOR JULY

⑈40326⑈ ⑆000000518⑆ 486070057⑈ 110722

United States Treasury 15-51 000 B 418,708,832

Check No.

07 01 22 28045300 KANSAS CITY, MO 4033 86475830
000780400010 4033 86475830 S 0000220623C1M3

Pay to the order of
JOANN T MALDONADO
2715 W HARRISON ST
CHICAGO IL 60612 3422

$*****103*80

VOID AFTER ONE YEAR

REGIONAL DISBURSING OFFICER 008

Vora L. Robinson

071204

SOC SEC FOR JUN

⑈40337⑈ ⑆000000518⑆ 864758301⑈ 070722

United States Treasury 15-51 000 B 421,838,116

Check No.

09 01 22 28040004 KANSAS CITY, MO 4032 49066322
000785884454 4032 49066322 W 00000220820MDM

Pay to the order of
JOANN T MALDONADO
2715 W HARRISON ST
CHICAGO IL 60612 3422

$*****246*90

VOID AFTER ONE YEAR

REGIONAL DISBURSING OFFICER
008

SSI FOR SEPTEMBER

027256

⑈40326⑈ ⑆000000518⑆ 49066322⑈ 110922

Human Services Campus

Client Grievance Form

"OFFICIAL SEAL" ODALYS FIS Notary Public, State of Illinois My Commission Expires Nov. 05, 20[illegible]

Clients who have complaints pertaining to Human Services Campus (HSC) services are encouraged to fill out this form and return it to the Welcome Center front desk or LDRC front desk. It is important that the client fill out the contact information as accurately as possible so HSC staff can contact the client. However, you have the right to remain anonymous while submitting your concerns.

Client Name: Jo Ann Maldonado Date of Birth: 01/24/1966 HMIS Number: 1041219

Client contact info: (Please include all relevant – phone, email, address, case manager)

480-647-9454, joannmldnd@gmail.com, 232 12th St. 22-21

Staff accepting form: ______ Date: ______

NOV 11, 2020 Volunteer military in the kitchen I informed of voting violation & asked for help as well as my bravery be circulated through the HOMELESSNESS. Any more wrong I want Justice!! I want to be healthy, have a home & not be Covid-19 Quarantine

You may use additional paper if needed.

Location/Program of Incident: Phoenix Inn Covid-19 ~~of the wrongful doings~~ Today I was threatened by

~~I called [illegible] 2 times because~~

I was denied the right to leave quarantine & go vote.
Told by staff "NO" I could not go however, Julia & "D" were told they could. I did not get care medical as I should have. Dexamethasone given on day 10, released on day 11 to CASS where someone gave me covid-19 14 DAY QUARANTINE PER CDC in CA because it's not mandatory to test & staff breaks rules for favored client's. My Oct 28, 2020 positive result's were given & shown to Katrina ("Trina") I believe her bed # is 221. She told me staff gave her the stack of 15 with photo's [illegible] [illegible] the HIPPA law. In San Diego I posted the paper on Facebook when I was refused the right to test by staff of Father Joe's Village
1986–1988 Chicago, [illegible] 3445 N. Melro[se]
I petitioned for signature's as a Republican in Chicago, Ill.

Julia in Ch[icago] whom is c[illegible] Mani[illegible] She [illegible] & my wash the la[illegible] day [illegible] was in level Oct [illegible] 20[illegible] I b[illegible] My c[illegible] not [illegible] I w[illegible] also [illegible] [illegible] -S[illegible] with[illegible] [illegible]

For HEALTH CARE with Mayor Jane Byrne & Ronald Reagan President. The Democrat's did not want to & I went to school at Whitney Young [illegible] which they did not choose. I DID!!! as Well as Michelle Obama [illegible] Crusted Scabies cured after 4 yrs of suffer[ing] [illegible] [illegible]ite's Norwegian [illegible] diet was deli[illegible] [illegible]

Jo Ann T. Maldonado

Jo Ann T. Azmeh Maldonado 3-4-22

	ELK GROVE VILLAGE POLICE 901 Wellington Ave Elk Grove Village, IL 60007 (847) 357-4100	Occurred on Date/Time 1/7/2022 17:14:00 Occurred Between Date/Time:
Officer Narrative		
Case Number:		Reported On
EGP22-000429		1/7/2022 17:14:00

Officer Narrative

Incident Type:	Public Service Information For Police	Date of Report:	1/7/2022 18:38:00
Narrative Type:	Initial	Entered By:	2124 - STENCEL, MATTHEW JOHN

Narrative:

On 010722 at approximately 1714 hours I responded to a report of a fraud later changed to an information for police. While en route I was advised the complainant would be able to conduct an over the phone report for issues with her Social Security check deposit.

I subsequently called and spoke to the complainant Joann T Maldonado F/U 012466. Maldonado informed me she was having an issue with the Social Security office due to an improper change to the city of her address. When she called the office a representative told her they would correct the issue however the amount that would be sent was less than she was expecting. She believed this was due to issues she told me she was having years prior in California involving the CDC, hospitals, attorneys, federal agencies, and other police departments concerning various reports on incidents she made out there.

I advised Maldonado if she was unhappy with the Social Security office representative she spoke to that she could call them back on Monday and ask for a supervisor to explain her concerns. Maldonado was also told to follow up with any other agencies if she had issues concerning their respective cases from the past. She was then provided a case number for this incident and after advising her on how to follow up with her deposit concerns I cleared the scene.

No further action taken.

ELINOR SRO LLC

NOTICE OF TEMPORARY RELOCATION

09/04/2024

JoAnn Maldonado
3216 N Cicero Ave
Unit 403
Chicago, IL 60641

Dear: JoAnn,

Soon we will be rehabbing the unit you currently occupy. You will NOT be able to reside in your unit while the unit is rehabbed. Management has a unit for you to move into on a temporary basis. We expect rehab to be complete before December 20, 2024.

You only need to bring your personal belongings including any storage containers. We expect this move to begin this weekend. If you want anything thrown away, leave those items in your current unit.

You are scheduled to move into unit: 408

We are still coordinating keys and access. You will have keys for both units during the time of your move. You will surrender the keys for your current unit when rehab begins.

Your mail and rent will all be tied to your current unit number. When you pay rent, please reference your current unit number.

Please contact Julia, 773-283-3100, with any questions. There are a lot of moving parts and we sincerely appreciate your patience and flexibility.

Thank you,

AMERICAN ALLIANCE
CASUALTY COMPANY
9600 Bryn Mawr Avenue, Suite 275, Rosemont, IL 60018 (847) 916-3200
www.myamericanalliance.com

10/8/2014

Joann Maldonado
299 17th Street
San Diego, CA 92101

Policy Number: ILAA0090189
Claim Number:2013C0008283
Date of Loss: 7/13/2013

Dear Joann Maldonado:

Please be advised, after careful review of your medical bills and records, we have decided to extend an offer of settlement in the amount of $2,500.00 to bring this matter to close.

Certainly and in the meantime should you have any questions, please feel free to contact me.

Very truly yours,
Sergio Cosentino
American Alliance Casualty Company
847-916-3241

CASE NAME:	CASE NUMBER:

5 a. Put all items checked in item 2c and your completed *Declaration of Custodian of Records* form in an envelope. (You can ask the person in item 4 where to get this form.) Attach a copy of page 1 of this order to the envelope.

b. Put the envelope inside another envelope. Then, attach a copy of page 1 of this form to the outer envelope or write this information on the outer envelope:

(1) Case name
(2) Case number
(3) Your name
(4) Hearing date, time, and department

c. Seal and mail the envelope to the Court Clerk at the address listed in ☐ item 3 or ☐ The court address in the caption on page 1 . You must mail these documents to the court within five days of service of this order.

d. If you are the Custodian of Records, you must also mail the person in item 4 a copy of your completed *Declaration of Custodian of Records*. Do not include a copy of the documents.

The server fills out the section below.

Proof of Service of CR-125/JV-525

1. I personally served a copy of this subpoena on:
Date: 11/11/19 Time: 11:34 AM ☒ a.m. ☐ p.m.
Name of the person served: ~~Kenya~~ → ~~Dr Morris~~ Lt. Payne
At this address: 1501 Imperial Ave SD, CA 92101
After I served this person, I mailed or delivered a copy of this Proof of Service to the person in item 4 on *(date)*: 11/18/19
Mailed from *(city)*:

2. I received this order for service on *(date)*: _____ and was not able to serve *(name of person)* Lt. Payne after *(number of attempts)* 1 attempts because:

a. ☐ The person is not known at this address.
b. ☐ The person moved and the forwarding address is not known.
c. ☐ There is no such address.
d. ☐ The address is in a different county.
e. ☐ I was not able to serve by the hearing date.
f. ☐ Other *(explain)*:

3. Server's name: JoAna Maldonado Phone no. 3128261533

4. The server *(check one)*
a. ☐ is a registered process server.
b. ☒ is not a registered process server.
c. ☐ is a sheriff, marshal, or constable.
d. ☐ works for a registered process server.
e. ☐ is exempt from registration under Business and Professional Code section 22350(b).

5. Server's address: General Delivery 2201 Midway Dr SD, CA 92110

If server is a registered process server:
County of registration: _____ Registration no.: _____

I declare under penalty of perjury under the laws of the State of California that I am at least 18 years old and not involved in this case and the information above is true and correct.

Date: 11/18/19

▶ _____
TYPE OR PRINT NAME OF SERVER

▶ JoAna Maldonado
SIGNATURE OF SERVER

ORDER TO ATTEND COURT OR PROVIDE DOCUMENTS:
Subpoena/Subpoena Duces Tecum
(Criminal and Juvenile)

LEGAL AID SOCIETY OF SAN DIEGO, INC.
Office of the Public Attorney
1764 San Diego Avenue, Suite
San Diego, CA 92110
Telephone: 877 534-2524
Facsimile: 619 471-2653
www.lassd.org

Wednesday, May 9, 2018

Ms. JoAnn Maldonado
759 8th Street
San Diego, CA 92101

RE: SSI

Dear Ms. Maldonado,

I have recently received verification from Social Security that you are now receiving your disability benefits. It appears that all outstanding issues I can be of assistance with have been resolved. As such, I will be closing your Social Security Disability file with Legal Aid. If you feel that there are still other Social Security matters that you need assistance with, please contact me as soon as possible.

As you are now receiving disability benefits, please be aware that from time to time, Social Security may review your case in order to determine if you are still disabled. For this reason, it is important that you stay in treatment, follow your doctor's advice, and refrain from using intoxicating substances. Failure to do so may result in your benefits being terminated upon review. Your benefits may also be automatically terminated if you spend 12 consecutive months in incarceration.

If in the future, you feel you may be able to return to work, please consult Social Security's programs and rules at http://www.ssa.gov/redbook/index.html. You must report any earnings to Social Security. Finally, it is important that you timely respond to any communications or requests from Social Security and keep them updated with your current contact information.

I hope this letter finds you well. It has been a pleasure helping you obtain benefits. If you have any questions regarding this letter, please do not hesitate to contact me. I wish you the best of luck in the future.

Sincerely,

Adalberto Murillo

MISCELLANEOUS INCIDENT EXCEPTION REPORT
CHICAGO POLICE DEPARTMENT

BEAT/UNIT ASSIGNED	BEAT/OCC	DATE REPORTING OFFICER(S) ARRIVED-TIME
1602	1215	27 JAN 23 1815HRS

NATURE OF INCIDENT: LOST-FOUND INFORMATION

LOCATION OF INCIDENT: 743 N. ARMOUR ST CHICAGO IL

NAME OF COMPLAINANT	ADDRESS (IF SAME AS LOCATION WRITE -DNA-)	PHONE NO.
JOHN T. MALDONADO	900 LANDMEIER RD ELMHURST	773-942-3885

NARRATIVE:

WRONG YEAR STATED, NEEDS CORRECTED DATE IS NEEDED IMMEDIATELY

ASSIGNMENT COMPLETED AT			
0536 HRS			
REPORTING OFFICER / STAR NO.	REPORTING OFFICER / STAR NO.	SUPERVISOR APPROVING	STAR NO.

CPD-11.419 (7/72)

ILLINOIS STATE BAR ASSOCIATION
LAWYER REFERRAL SERVICE

PO Box 2096 Springfield, IL 62705-2096 (800) 922-8757 or (217) 525-5297

September 27, 2022

Joann Maldonado
2715 W Harrison St.
Chicago, IL 60612

This letter is to confirm that you have been referred to the attorney in the area(s) of:
Medical Malpractice

We suggest that you call the attorney promptly and arrange for your appointment. The attorney will not contact you. Please be sure to tell the attorney you were referred by the Illinois Lawyer Finder.com

Christopher M. Norem
221 N LaSalle St Ste 1750
Chicago, IL 60601-1516
(312) 641-5926

Notice: ***The attorney to whom you have been referred has agreed to provide an initial consultation of up to 1/2 hour for $25.00. Any further financial or representational arrangements are between you and the attorney and are on such terms as you agree. Please pay the attorney at the time of your appointment.***

Thank you for this opportunity to serve you.

Ref #: 198182

Appeal onset

Form **SSA-561-U2** (12-2016) uf (12-2016)
Prior Edition May Be Used Until Exhausted
Social Security Administration

OMB No. 0960-0622

REQUEST FOR RECONSIDERATION

NAME OF CLAIMANT:	CLAIMANT SSN:	CLAIM NUMBER: *(If different than SSN)*
JOANN THERESA MALDONADO	360-60-2956	

ISSUE BEING APPEALED: *(Specify if retirement, disability, hospital or medical, SSI, SVB, overpayment, etc.)*
DISABILITY BENEFITS WIDOW & SST 1989 PTSD URINAR
MIGRAINE W/ TUNNEL VISION, FIBROMYALGIA, ANEMIA 2011
1999 DISABLEMENT, HEAD, BRAIN INJURY, SPINAL (R) Leg 2014
2003 2005 PTSD

I do not agree with the Social Security Administration's (SSA) determination and request reconsideration.
My reasons are:
I BELEIVE I WAS DISABLED BEFORE 8/17. I BELEIVE
I WAS DISABLED WITH MIGRAINE'S TUNNEL VISION AS A CHILD & H
URETHRA, FIBROMYALGIA, PTSD FROM WITNESSING & MY HUSBANDS ACCIDENT 7/7/198
sidney,
MY ACCIDENT WITH SPINAL, INTERNAL & BRAIN INJURIES OCT. 19, 1999.

SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) RECONSIDERATION ONLY

THREE WAYS TO APPEAL

I want to appeal your determination about my claim for **SSI** or **SVB**. I have read about the three ways to appeal.
I have checked the box below:

- ☐ **CASE REVIEW - You can pick this kind of appeal in all cases.** You can give us more facts to add to your file. Then we will decide your case again. You do not meet with the person who decides your case.
- ☐ **INFORMAL CONFERENCE - You can pick this kind of appeal in all SSI cases except for medical issues. In SVB cases, you can pick this kind of appeal only if we are stopping or lowering your SVB payment.** You will meet with a person who will decide your case. You can tell that person why you think you are right. You can give us more facts to help prove you are right. You can bring other people to help explain your case.
- ☐ **FORMAL CONFERENCE - You can pick this kind of appeal only if we are stopping or lowering your SSI or SVB payment.** This meeting is like an informal conference, but we can also get people to come in and help prove you are right. We can do this even if they do not want to help you. You can question these people at your meeting.

CONTACT INFORMATION

CLAIMANT SIGNATURE - *OPTIONAL*: Joann Maldonado

NAME OF CLAIMANT'S REPRESENTATIVE: *(If any)* moved into New Address Shelter (Door of Hope) 90 days

MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
~~739 8th St~~ P.O. Box 120569	~~San Diego~~ Chula Vista	CA	~~92101~~ 91912
MAILING ADDRESS: Health Center Drive 2799 [redacted]	CITY: San Diego, CA.	STATE:	ZIP CODE: 92123

TELEPHONE NUMBER: *(Include area code)*	DATE:	TELEPHONE NUMBER: *(Include area code)*	DATE:
619-453-4241	4-25-18	858 279 1100	4/27/18

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ Yes ☐ No
2. IS THIS REQUEST FILED TIMELY? ☐ Yes ☐ No
   (If "NO", attach claimant's explanation for delay. Refer to GN 03102.125)

SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED:

SAN DIEGO, CALIFORNIA
MAY 02 2018
SSA DISTRICT OFFICE

FIELD OFFICE DEVELOPMENT (GN 03102.300)

- ☐ NO FURTHER DEVELOPMENT REQUIRED
- ☐ REQUIRED DEVELOPMENT ATTACHED
- ☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SSI CASES ONLY - GOLDBERG KELLY (GK) (SI 02301.310) RECIPIENT APPEALED AN ADVERSE ACTION:

- ☐ WITHIN 10 DAYS AFTER RECEIVING THE ADVANCE NOTICE;
- ☐ AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT
- ☐ PAYMENT CONTINUATION APPLIES AND INPUT MADE TO SYSTEM

NOTE: Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post and keep a copy for your records.

Claims Folder

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0144

DISABILITY REPORT – APPEAL

For SSA use only. Please do not write in this box.

Related SSN _____ Number Holder _____

If you are filling out this report for someone else, please provide information about him or her. When a question refers to "you" or "your," it refers to the person who is applying for disability benefits.

SECTION 1 – INFORMATION ABOUT THE DISABLED PERSON

1. A. Name (First, Middle, Last, Suffix)

Mrs. JoAnn Theresa Maldonado

1. B. Social Security Number spouse

360602956/114525497

1. C. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

619 453 4241

☐ Check this box if you do not have a phone number where we can leave a message.

1. D. Alternate Phone Number – another number where we may reach you, if any

1. E. Email Address (Optional)

joann.maldonado9686@gmail.com

SECTION 2 – CONTACTS

Give the name of someone **(other than your doctors)** we can contact who knows about your medical conditions, and can help you with your claim. (e.g., friend or relative)

2. A. Name (First, Middle, Last)

Paul Harry Szwed

2. B. Relationship to Disabled Person

Brother

2. C. Mailing Address (Street or PO Box), include apartment number or unit if applicable.

6450 W Berteau

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Chicago	IL.	60636	US

2. D. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

312 493 5044

2. E. Can this person speak and understand English?

☒ Yes ☐ No

If no, what language does the contact person prefer? _____

2. F. Who is completing this form?

☒ The person who is applying for disability (Go to SECTION 3 - MEDICAL CONDITIONS).
☐ The person listed in 2.A. (Go to SECTION 3 - MEDICAL CONDITIONS).
☐ Someone else (Please complete the information below).

2. G. Name (First, Middle, Last)

Antoinette Estele Weaver

2. H. Relationship to Disabled Person

Cousin

2. I. Mailing Address (Street or PO Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Warrensburg	MO		

2. J. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

1630346 2671

SECTION 4 – MEDICAL TREATMENT (continued)
Provider 1

4. D. Name of facility or office	Name of health care provider who treated you
City Heights FHCC	Dr. Brandon Brown

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)
619 515 2400	860417

Address: 5454 El Cajon Blvd.

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
City Heights	CA	92115	US

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic or Outpatient visits at this facility
First Visit 11/17
Last Visit 4/27/18
Next scheduled appointment (if any) 5/07/18 9:30

Emergency Room visits at this facility
Date 4/15/18
Date
Date
☐ None

Overnight hospital stays at this facility
Date in ____ Date out ____
Date in ____ Date out ____
Date in ____ Date out ____
☐ None

What medical conditions were treated or evaluated?
Fibromialgya & scabies or skin condition now

What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)
Lyrica which Carefirst has not filled prescription yet.

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☒ Yes (Please complete the information below.) ☐ No (Go to the next page.)

KIND OF TEST	DATES OF TESTS	KIND OF TEST	DATES OF TESTS
☒ Biopsy (list body part) uterus	2/18	☒ MRI/CT Scan (list body part) neck & head	4/ /18
☒ Blood Test (not HIV)	4/27/18	☐ Speech/Language Test	
☐ Breathing Test		☐ Treadmill (exercise test)	
☐ Cardiac Catheterization		☐ Vision Test	
☐ EEG (brain wave test)		☒ X-ray (list body part) neck & head	/18
☐ EKG (heart test)			
☐ Hearing Test		☒ Other (please describe) thyroid blood work A fib - possible med's urinary infection/kidneys	
☒ HIV Test	4/27/18		
☐ IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you do not have any more providers to describe,
go to SECTION 5 – OTHER MEDICAL INFORMATION on page 6.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0144

DISABILITY REPORT – APPEAL

For SSA use only. Please do not write in this box.

Related SSN _____ Number Holder _____

If you are filling out this report for someone else, please provide information about him or her. When a question refers to "you" or "your," it refers to the person who is applying for disability benefits.

SECTION 1 – INFORMATION ABOUT THE DISABLED PERSON

1. A. Name (First, Middle, Last, Suffix)

Mrs. Jo Ann Theresa Maldonado

1. B. Social Security Number spouse

360602956/114525497

1. C. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

619 453 4241

☐ Check this box if you do not have a phone number where we can leave a message.

1. D. Alternate Phone Number – another number where we may reach you, if any

1. E. Email Address (Optional)

joann.maldonado9686@gmail.com

SECTION 2 – CONTACTS

Give the name of someone **(other than your doctors)** we can contact who knows about your medical conditions, and can help you with your claim. (e.g., friend or relative)

2. A. Name (First, Middle, Last)

Paul Harry Szwed

2. B. Relationship to Disabled Person

Brother

2. C. Mailing Address (Street or PO Box), include apartment number or unit if applicable.

6450 W Berteau

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Chicago	IL.	60636	US

2. D. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

312 493 5044

2. E. Can this person speak and understand English?

☒ Yes ☐ No

If no, what language does the contact person prefer? _____

2. F. Who is completing this form?

☒ The person who is applying for disability (Go to SECTION 3 - MEDICAL CONDITIONS).
☐ The person listed in 2.A. (Go to SECTION 3 - MEDICAL CONDITIONS).
☐ Someone else (Please complete the information below).

2. G. Name (First, Middle, Last)

Antoinette Estele Weaver

2. H. Relationship to Disabled Person

Cousin

2. I. Mailing Address (Street or PO Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Warrensburg	MO		

2. J. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

1630 346 2671

SECTION 3 – MEDICAL CONDITIONS

3. A. Since you last told us about your medical conditions, has there been any **CHANGE** (for better or worse) in your physical or mental conditions?

☒ Yes, approximate date change occurred: 4/18 ☐ No

If yes, please describe in detail: Nerves in legs hurt severely more than rest of my body. I have not been able to get Lyrica prescription filled by CVS on 5th & C St.

3. B. Since you last told us about your medical conditions, do you have any **NEW** physical or mental conditions?

☒ Yes, approximate date of new conditions: rash all over ☐ No

If yes, please describe in detail: Very itchy rash that has not gone away (possible scabies 5 months)

If you need more space, use SECTION 10 – REMARKS on the last page.

SECTION 4 – MEDICAL TREATMENT

4. A. Have you used any other names on your medical or educational records? Examples are maiden name, other married name, or nickname.

☒ Yes ☐ No

If yes, please list the other names used: JoAnn Szwed

4. B. Since you last told us about your medical treatment, have you seen a doctor or other health care provider, received treatment at a hospital or clinic, or **do you have a future appointment scheduled?**

☒ Yes ☐ No (Go to SECTION 6 – MEDICINES)

4. C. What type(s) of condition(s) were you treated for, or will you be seen for?

☒ Physical ☐ Mental (including emotional or learning problems)

If you answered "Yes" to 4.B., please tell us who may have **NEW** medical records about any of your **physical or mental** conditions (including emotional or learning problems).

Use the following pages to provide information for up to three (3) providers. **Complete one page for each provider.** If you have more than three providers, list them in SECTION 10 - REMARKS on the last page.

Please include:

- doctors' offices
- hospitals (including emergency room visits)
- clinics
- mental health center
- other health care facilities.

Only list the providers you have seen since you last told us about your medical treatment.

SECTION 5 – OTHER MEDICAL INFORMATION

5. **Since you last told us about your other medical information**, does anyone else have **medical information** about any of your **physical or mental** conditions (including emotional and learning problems) or are you scheduled to see anyone else?
This may include:
- workers' compensation
- vocational rehabilitation services
- insurance companies who have paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

☒ Yes (Please complete the information below.)
☐ No (Go to SECTION 6 – MEDICINES)

Name of Organization	Claim or ID Number (if any)
~~Maria Corcoran~~ Health & Human Services	

Address: 10th St

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
San Diego	CA	92101	US

Name of Contact Person	Phone Number
Maria Corcoran	

Date of First Contact	Date of Last Contact	Date of Next Contact (if any)
2017	2018	6/18

Reasons for Contacts: case worker

If you need to list more people or organizations, use SECTION 10 – REMARKS on the last page.

SECTION 6 – MEDICINES

6. **Are you currently taking any medicines (prescription or non-prescription)?**
☒ Yes (Please complete the information below. You may need to look at your medicine containers.)
☐ No (Go to SECTION 7 – ACTIVITIES)

NAME OF MEDICINE	IF PRESCRIBED, NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE
Gabapentin 600mg 3x's day	Dr. Russell	Fibromyalgia Nueropathy	dizziness, drowsy
Prednisone 20mg			n/a
Tylenol Extra Strength 500mg		Pain & headache	some relief
Zantac		heartburn	n/a
Ferrous Sulfate		anemia	constipation
Permitherin		scabies	n/a
Docusate Sodium		stool softner	n/a

If you need to list more medicines, use SECTION 10 – REMARKS on the last page.

SECTION 4 – MEDICAL TREATMENT (continued)
Provider 3

4. D. Name of facility or office	Name of health care provider who treated you
FHCC	Dr Stacy Uttle

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)
619-575-2300	

Address: 5th Ave Downtown

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
San Diego	CA	92101	US

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic or Outpatient visits at this facility	Emergency Room visits at this facility	Overnight hospital stays at this facility
First Visit 2013	Date	Date in ____ Date out ____
Last Visit 4/21/18	Date	Date in ____ Date out ____
Next scheduled appointment (if any)	Date	Date in ____ Date out ____
	☐ None	☐ None

What medical conditions were treated or evaluated?

Pain, anemia, uterus damage bleed 32 days straight

What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

Wrote a prescription for Lyrica which wasn't approved

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☐ Yes (Please complete the information below.) ☒ No (Go to the next page.)

KIND OF TEST	DATES OF TESTS	KIND OF TEST	DATES OF TESTS
☐ Biopsy (list body part)		☐ MRI/CT Scan (list body part)	
☐ Blood Test (not HIV)		☐ Speech/Language Test	
☐ Breathing Test		☐ Treadmill (exercise test)	
☐ Cardiac Catheterization		☐ Vision Test	
☐ EEG (brain wave test)		☐ X-ray (list body part)	
☐ EKG (heart test)			
☐ Hearing Test		☒ Other (please describe)	
☐ HIV Test		pain medication/ Lyrica	
☐ IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you have been treated by more providers, use section 10 - REMARKS on the last page.

SECTION 10 – REMARKS

Use this space to provide any information you could not show in earlier sections of this form or any additional information you feel we should know about. Please be sure to include the number of the question you are answering (For example, 3A, 4D, etc.).

10-8-2009 Dr. Parini, Las Vegas, NV was the first medical provider to do test for the severe pain I was having in my right hip & thigh. He then was the 1st DR to diagnosis my IT syndrom.
Nevada Ortho pedic & Spine treated me through physical
2000-2009 therapy for my spine, neck & right foot pain & divergement with a locked limb (R leg) torn meniscus.
1977-1979 Dr Villaba in Chicago, IL treated me several times for my urethra stretching & micro tube. (St Elizabeth's Hosp)
1980-1990 Northwestern Memorial Hosp treated me for migraines with tunnel vision. Located in Chicago, IL.

2011 San Diego Legal Aid - Beto Murillo Representative for SSDI/SSI with da
2011 Stark & Stone Law Firm was representing me until I moved out of Las Vegas, NV & are aware of my disabilities due to the car accident on Oct 19, 1999 or da
011 Head injury from DV incident 10/2011 & PTSD 114-53-5475
1/2/19 PTSD, Car accident that killed my Husband, Jorge Luis Nadeau
999 PTSD, car accident that disabled me Oct 19, 1999
PTSD, car accident that worsened old injuries & led new injuries.
2012 PTSD, Vocal & neck (whiplash) R leg & spine, neck
PTSD, 12/31/14 baby murdered at CSD Hosp incorrect medical care record of removal of deceased foetus.
I Fear driving a vehicle

Chronic Pain 1999, Oct 19 injuries
UMC, Med Clinic LV, NV
Nevada Orthopedic & Spine LV, NV
MLK Clinic LV, NV
Dr Parini. LV, NV

None prenatal care at Father Joe's Clinic & Rogers Clinic after incident forced to wait 3 days for medical attention. I have permanent uterine & blood clot damage & bad pain (Scripps Mercy Hosp)

Date Report Completed MM/DD/YYYY:

SECTION 7 - ACTIVITIES

7. Since you last told us about your activities, has there been any **change** (for better or worse) in your daily activities due to your **physical or mental** conditions? (Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.)

☒ Yes ☐ No

If yes, please describe in detail: Have trouble sleeping due to itchy rash & nerve severity irritation in legs IT Syndrom in R side - painful

If you need more space, use SECTION 10 – REMARKS on the last page.

SECTION 8 – WORK AND EDUCATION

8. A. Since you last told us about your work, have you worked or has your work changed?

☐ Yes ☒ No

If yes, you will be asked to provide additional information.

8. B. Since you last told us about your education, have you completed or are you enrolled in any type of specialized job training, trade school, or vocational school?

☐ Yes ☒ No

If yes, what type? _____

Date(s) attended: _____

If you need more space, use SECTION 10 – REMARKS on the last page.

SECTION 9 – VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES

9. Since you last told us about your vocational rehabilitation, have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program?
- an individualized plan for employment with a vocational rehabilitation agency or any other organization?
- a Plan to Achieve Self-Support (PASS)?
- an individualized education program (IEP) through an educational institution (if a student age 18-21)?
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ Yes (Please complete the information below.)

☒ No (Go to SECTION 10 – REMARKS)

Name of Organization or School

Nevada Rehabilitation - 2007

Name of Counselor, Instructor, or Job Coach	Phone Number

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Las Vegas, NV	NV	8911	US

Date when you started participating in the plan or program:

If you need more space, use SECTION 10 – REMARKS on the last page.

To: Metro Frc District From: aton

IMAGED AS RECEIVED

POOR QUALITY

90-250 APPENDIX B. FORM 11-45G HHSA

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY

District Office: _____ Worker #: _____
Appointment Date: _____

Clinic use only
No Show: _____
Signature: _____
Date: _____

GENERAL RELIEF EMPLOYABILITY EVALUATION (GREE)

Please Print
Name: JoAnn Maldonado SSN: [redacted] DOB: 01/24/66 Case #: _____

Patient's statement of medical condition: Unable to work - Anemia, Vertigo, Fibromialgya, tora gland meniscus Okies, baker's cyst, tora tendon, ligament, ACL damaged, Bleine, patty leg collapses, back & neck damaged, Lacerations, Congestion or withdrawal Uterus damaged by DV 12-31-14 hurts to sit, Hot to time, Headaches, Nervous System damage.

AUTHORIZATION FOR RELEASE OF INFORMATION AND SWORN STATEMENT

I hereby authorize the release of medical findings to the County of San Diego, Health and Human Services Agency, my medical providers, and the provider where my ability to work will be evaluated. I also understand that I must provide a medical statement if I am unable to work, and if I go to my own doctor to get a medical statement, the County of San Diego will not pay for it.

Under penalty of perjury, I attest that the above statement is true. I understand that I may be sanctioned if I provide false information.

JoAnn Maldonado — Applicant's Signature

4-16-18 — Date

Treatment Information (a GREE appointment is not considered treatment)	Yes/No	# of Times Seen in Last 6 Months	Where? (name/address/clinic)
1. Currently getting treatment for the condition stated above?	Yes	Date of Last Visit: April 2018	Family Health Centers
2. Eligible to or getting:			
a. County Medical Services?	Yes		
b. Mental Health Services?	Yes		
c. Alcohol or Drug Services?	No		

Employability Status (please check only one) INSTRUCTIONS FOR MEDICAL PROVIDER ON REVERSE SIDE OF THIS FORM

A. __ Can do GR Work Project (no restrictions)
B. __ Can do Light Duty GR Work Project through the end of __/__ (Month/Year)
Please list restrictions for light duty _____
C. X Unable to work through the end of 4/18 (Month/Year)
Diagnosis: _____

COMMENTS: Chronic Pain — Continue F/u c PCP & specialists
Hemorrhoids

I certify that I have evaluated the above named patient and that these statements are a true record of my medical findings as related to the patient's statement of medical condition.

Kelly Jarvis PA-C, MPH — NAME/TITLE (PLEASE PRINT)

Kelly Jarvis — SIGNATURE

Dr. Armenta — PHYSICIAN'S NAME (PLEASE PRINT)

Family Health Centers Community Health Centers — 4171 Fairmount Ave — STREET ADDRESS — San Diego, CA. 92105 — CITY/STATE/ZIP — Ph. 619-280-4213

4-16-18 — DATE

#21625 — MEDICAL LICENSE NUMBER

TELEPHONE NO.

Form SSA-561-U2 (10-2022) UF
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-0(

REQUEST FOR RECONSIDERATION

NAME OF CLAIMANT:	CLAIMANT SSN:	CLAIM NUMBER: *(If different than S*
JoAnn T. Maldonado	366602956	

ISSUE BEING APPEALED: *(Specify if retirement, disability, hospital or medical, SSI, SVB, overpayment, e*
W. lower disabled qualification payment's T overpayment was F is c
My fault? caused credit damages F health issues including
hospitalization again, St Joseph Hosp. Phoenix AZ F St Mary's Hosp Ch

I do not agree with the Social Security Administration's (SSA) determination and request reconsideration.
My reasons are: Assaulted while staying in the shelter Franciscan Outreach as w
Employee did not correctly F honestly do what they should. F retalia
causing pain F suffering also now. Held the employees accou

SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVE RECONSIDERATION ONLY

THREE WAYS TO APPEAL

I want to appeal your determination about my claim for **SSI** or **SVB**. I have read about the three ways to appeal.
I have checked the box below:

- [X] **CASE REVIEW - You can pick this kind of appeal in all cases.** You can give us more facts to add to your file. Then we will decide your case again. You do not meet with the person who decides your case.
- [X] **INFORMAL CONFERENCE - You can pick this kind of appeal in all SSI cases except for medical issues. Ir SVB cases, you can pick this kind of appeal only if we are stopping or lowering your SVB payment.** You w meet with a person who will decide your case. You can tell that person why you think you are right. You can give more facts to help prove you are right. You can bring other people to help explain your case.
- [X] **FORMAL CONFERENCE - You can pick this kind of appeal only if we are stopping or lowering your SSI o SVB payment.** This meeting is like an informal conference, but we can also get people to come in and help prove you are right. We can do this even if they do not want to help you. You can question these people at your meetin

CONTACT INFORMATION

CLAIMANT SIGNATURE - *OPTIONAL:*	NAME OF CLAIMANT'S REPRESENTATIVE: *(If a*
JoAnn Maldonado	
MAILING ADDRESS: 1521 N. Sedgwick St.	MAILING ADDRESS:
CITY: Chicago STATE: IL ZIP CODE: 60610	CITY: STATE: ZIP CODE:
TELEPHONE NUMBER: *(Include area code)* 7739423885 DATE: 12-23-22	TELEPHONE NUMBER: *(Include area code)* DATE:

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ Yes ☐ No
2. IS THIS REQUEST FILED TIMELY? ☐ Yes ☐ No
   (If "NO", attach claimant's explanation for delay. Refer to GN 03101.020)

SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED:

FIELD OFFICE DEVELOPMENT (GN 03102.300)
- ☐ NO FURTHER DEVELOPMENT REQUIRED
- ☐ REQUIRED DEVELOPMENT ATTACHED
- ☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAY

SSI CASES ONLY - GOLDBERG KELLY (GK)
(SI 02301.310) RECIPIENT APPEALED AN ADVERSE ACTION:
- ☐ WITHIN 10 DAYS AFTER RECEIVING THE ADVANCE NOTICE;
- ☐ AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT
- ☐ PAYMENT CONTINUATION APPLIES AND INPUT MADE TO SYSTEM

NOTE: Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office i Manila, or any U.S. Foreign Service post and keep a copy for your records.

Claimant

Form SSA-561-U2 (10-2022) UF
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-06

REQUEST FOR RECONSIDERATION

NAME OF CLAIMANT:	CLAIMANT SSN:	CLAIM NUMBER: *(If different than S*:
JoAnn T. Maldonado	360602956	

ISSUE BEING APPEALED: *(Specify if retirement, disability, hospital or medical, SSI, SVB, overpayment, et*
Overpayment & Widower's disability at age 50 as we
as from Widower to Widower disabled, SSA is not stable Pymt
w/dependants Harassment of 109, in Nov 2022 documented Cp

I do not agree with the Social Security Administration's (SSA) determination and request reconsideration.
My reasons are: Both denial of widower disabled since 1999 Oct 19th
I've been denied UBhonestly for yrs which caused more damage
to injured areas worsening health problems including shelter living dec
overpayment recovery SSA fault which I caught Covid 19 now like ar

SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVE

TIME, first time Pla
Briar Grove Ch
Second time Ch
Franciscan Outre

RECONSIDERATION ONLY

THREE WAYS TO APPEAL

I want to appeal your determination about my claim for **SSI** or **SVB**. I have read about the three ways to appeal.
I have checked the box below:

☒ **CASE REVIEW - You can pick this kind of appeal in all cases.** You can give us more facts to add to your file. Then we will decide your case again. You do not meet with the person who decides your case.

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CONTACT INFORMATION

CLAIMANT SIGNATURE - *OPTIONAL:*		NAME OF CLAIMANT'S REPRESENTATIVE: *(If a*	
JoAnn Maldonado			
MAILING ADDRESS:		MAILING ADDRESS:	
1521 N. Sedgwick St			
CITY: STATE: ZIP CODE:		CITY: STATE: ZIP CODE:	
Chicago IL 60610			
TELEPHONE NUMBER: *(Include area code)*	DATE:	TELEPHONE NUMBER: *(Include area code)*	DATE:
7733423885	12-23-22		

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ Yes ☐ No

2. IS THIS REQUEST FILED TIMELY? ☐ Yes ☐ No
(If "NO", attach claimant's explanation for delay. Refer to GN 03101.020)

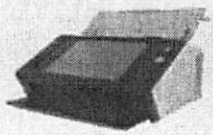
SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED:

FIELD OFFICE DEVELOPMENT (GN 03102.300)
☐ NO FURTHER DEVELOPMENT REQUIRED
☐ REQUIRED DEVELOPMENT ATTACHED
☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAY

SSI CASES ONLY - GOLDBERG KELLY (GK)
(SI 02301.310) RECIPIENT APPEALED AN ADVERSE ACTION:
☐ WITHIN 10 DAYS AFTER RECEIVING THE ADVANCE NOTICE;
☐ AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT
☐ PAYMENT CONTINUATION APPLIES AND INPU MADE TO SYSTEM

NOTE: Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office Manila, or any U.S. Foreign Service post and keep a copy for your records.

QuickScan Cover Sheet



Securing toda
and tomorrow

Which document(s) are you uploading today?

Due to SSA error of denial of spousal right by law & God.

- [X] Paystubs, Statement of Earnings, W2s, SSA-1099s, etc.
- [ ] SSA-501 Request for Hearing
- [ ] SSA-561 Request for Reconsideration
- [ ] SSA-632 Request for Waiver of Overpayment or Change in Repayment Rate
- [X] Other: Change to widower disabled & pay 01/22 thru 12/23 of py

Important Note: Original documents (Naturalization Papers, Marriage Records, Alien Registrations, Death Certificates, and Passports) must be viewed in-person and certified by a SSA Representative. These types of documents are NOT eligible for ***QuickScan.***

Your Name: JoAnn Maldonado Today's Date: 11/27/23

Your Phone Number: 224 279 7567

Your SSN or Claim Number: 114 52 5475 + 360602956

Are you submitting documents for or on behalf of someone else? [X] Yes [ ] No

If yes, provide their SSN or Claim Number: 360602956

Address: 4000 W. Montrose Ave #104

How many pages are you uploading today? 3

Did you receive a letter or message asking for this information? [ ] Yes [X] No

Should this document be routed to a specific SSA representative? [ ] Yes [X] No

If yes, provide their name or phone extension: _____

Privacy Act Statement
Collection and Use of Personal Information

Section 205(a) of the Social Security Act, as amended, allows us to collect your information, or the information you are submitting on behalf of another, in order to administer our programs. Providing the information is voluntary, but not providing the information may prevent us from providing the services requested. As law permits, we may use and share the information you submit, including with other Federal, State, and local agencies, contractors, employers, and others, as outlined in the routine uses in our System of Records Notices (SORN), including, but not limited to, 60-0089 and 60-0320, available at [redacted]. The information you submit may also be used in computer matching programs to establish or verify eligibility for Federal benefit programs and to recover debts and other amounts